Direct Deposit Authorization

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Schaumburg, IL 60173
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claims@mybenefitexpress.com

Direct Deposit will help you receive your reimbursement sooner!

PARTICIPANT INFORMATION

Employer Name: _____ **Employer/Location:** _____

Employee Name: _____ _____ _____
(First Name) (Middle Initial) (Last Name)

SSN/EEID: _____ **Date of Birth:** _____
(Optional)

Current Address: _____
(Street Address)

_____
(Floor or Apt No.)

_____
(City, State Zip)

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Married Filing Separately

Phone Number: _____ _____
(Cell Phone Number) (Home Phone Number)

DIRECT DEPOSIT AUTHORIZATION

I request my Section 125 claim reimbursement direct deposit be placed in the following account:

Institution	Bank ABA Number	Account Number	Account Type
			☐ Savings ☐ Checking

You must provide a voided check if you are requesting the funds be deposited into a checking account.
Do not use a deposit slip, the number could be invalid.

This information is for reimbursement use only and cannot be disclosed to an outside party without proper authorization from the above participant.

I authorize my reimbursements to be sent to the financial institution named above to be deposited in the designated account.

In the event funds are deposited erroneously into my account, I authorize my Section 125 administrator to debit my account(s) not to exceed the original amount of the credit.

I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the limitations of the ACH as well as my financial institution.

This authorization may be terminated at any time with written notification to WEX Health, Inc., with consideration for reasonable time to act on the receipt of such notification.

Participant Signature _____ **Date** _____

PLEASE RETURN THIS FORM TO ADDRESS OR FAX NUMBER AT TOP OF THE PAGE.